North Carolina Department of Health and Human Services

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

Division of Mental Health, Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, North Carolina 27699-3001
Tel 919-733-7011• Fax 919-508-0951
Michael Moseley, Director

Division of Medical Assistance
2501 Mail Service Center
Raleigh, North Carolina 27699-2501
Tel 919-857-4011• Fax 919-733-6608
L. Allen Dobson, Jr. MD, Assistant Secretary for Health Policy and Medical Assistance

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MEMORANDUM

TO: Legislative Oversight Committee
Local CFAC Chairs
NC Council of Community Programs
County Managers
State Facility Directors
LME Board Chairs
Advocacy Organizations
Commission for MH/DD/SAS
State CFAC
NC Assoc. of County Commissioners
County Board Chairs
LME Directors
DHHS Division Directors
Provider Organizations
MH/DD/SAS Professional and Stakeholder Organizations

FROM: Allen Dobson, MD LADmb
Mike Moseley MMM cw

SUBJECT: Enhanced Services Implementation Update # 7: Provisionally Licensed Staff

The approval and implementation of the new service definitions has brought to the forefront the issues of those mental health professionals who hold provisional licensure. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) convened a task force including representatives from the professional groups to begin to address this issue.

As a result of the work of that group, the Divisions of MH/DD/SAS and Medical Assistance have extended the original six-month post-implementation period regarding provisionally licensed outpatient therapists and non-licensed interns announced in the April 13, 2005 joint memo from the two Divisions. The extension is until June 30, 2007. This timeframe will allow many of the current provisionally licensed providers to complete the period of supervised service to obtain full licensure. It should be noted that provisionally licensed providers beginning their period of supervision at a later date may not be able to complete the full period of supervision required and may have to complete this requirement using new services as described in the attached grid. The provisionally licensed provider may continue to bill H-codes through the LME as authorized at this time. We are also exploring additional billing options that might be used by providers through June 30, 2007.

Please be aware that in the new service system, it is likely that LMEs will be authorizing less outpatient therapy as the new services are available in the community based setting. While the opportunity to provide outpatient treatment as a single modality of service will be limited, the new community based service system

will create many opportunities within the new definitions to provide clinical services and create new options for clinical supervision.

Provisionally licensed practitioners as well as provider agencies and LMEs are urged to review the attached grid. This grid illustrates the options available to provisionally licensed individuals who are qualified as Qualified Professionals to provide services within their scope of practice and receive clinical supervision in the new community based service array.

There are more steps that need to be taken regarding the issues of the provisionally licensed. The Division of MH/DD/SAS, in cooperation with the professional organizations, will be contacting the licensing boards of the various professions to make sure they are updated on system reform and the new service definitions and to discuss how the new community support definition can be used as part of the provisional licensee's year of clinical experience

Key points to keep in mind:

- All provisionally licensed providers are defined in the Division's rules as Qualified Professionals (QP), and are able to perform all of the duties associated with the QP in the service definitions. Note: The designation of "board eligible" for Licensed Professional Counselors is equivalent to "provisional license."

- Within the context of the comprehensive services (see attached grid), a QP will be employed as part of a team and will provide clinical services under a bundled rate. This moves the services from an outpatient individual and group therapy focus to a more community based/family oriented model of care; a tenant of the North Carolina reform.

- There is concern that there is little incentive for providers to hire provisionally licensed staff as QPs. Provider agencies should keep in mind that national accreditation is required of all providers within three years. National accreditation processes will require qualified staffing levels to reflect the intent of the new service definitions at the time the accreditation process occurs. Consequently, a provider who employs provisionally licensed individuals as QPs and creates incentives for provisionally licensed professionals to remain employed as fully licensed professionals in those settings would benefit in the long run by developing more clinically seasoned staff who would help meet the rigorous staffing requirements demanded by the national accreditation processes. It is also apparent from discussions with the Centers for Medicare and Medicaid Services (CMS) at the federal level, there they are placing much more emphasis on the supervision of paraprofessional staff. Having those staff supervised by QPs with provisional licenses would be very favorably regarded by CMS. These factors would suggest the necessity of additional trained staff for a quality workforce.

It is important to consider that consumer choice and quality oversight by the LMEs are an active part of any provider's success. The ability to build and maintain a quality workforce within each provider group will help assure success as consumers make informed choices, and indeed "vote with their feet." Consumers will select the most qualified providers based on staff competencies and quality provision of services in a best practice model of care. It is clear that attracting, grooming, and retaining well trained and highly qualified staff, including licensed professionals, will be critical to this success.

Please contact Dr. Michael Lancaster at (919) 733-7011 or Michael.Lancaster@ncmail.net if you have questions regarding this extension or the attached material.

cc: Secretary Carmen Hooker Odom
Allyn Guffey
Dan Stewart
DMH/DD/SAS Executive Leadership Team
William Lawrence, MD
Tara Larson
Carol Robertson
Angela Floyd
Rob Lamme
Kaye Holder
Wayne Williams